Patient Medical History

Date of Birth _____ *S.S. #* _____ *Today's Date* _____

Name _____
Last *First* *Middle*

Address _____
City *State* *Zip*

_____
Home Phone *Cell Phone* *Work Phone*

Spouses Name and Phone # (parent if minor) _____ *#* _____

Name of your insurance company? _____

*Is Insurance Under: Patient*_____ *Spouse*_____ *Other*_____

Insurance Policy Holders Information

Name _____

Social Security # _____ - _____ - _____ *Date of Birth* ___/___/____

Employers Name _____ *Employers Phone (____)* _____

Employers Address _____

Insurance Authorization: I hereby authorize Darren W. Sinopoli, D.M.D., to furnish copies of my records to my insurance company upon request. I hereby assign to Darren W. Sinopoli, D.M.D., all payments for dental services rendered to myself or my dependent. A copy of this signature is as valid as the original. I agree to be responsible for any copays, deductibles and/ or any charges not covered by my policy.

_____ _____
Signature *Please Print Name*

Please Circle EACH Condition that Pertains to You, Previously or Currently
Your answers are for our records ONLY and will be considered Confidential.

AIDS	Epilepsy	Joint Replacement	Rheumatic Fever
Angina	Heart Attack	Kidney Disease	Sinus Problems
Arrhythmia	Herpes	Liver Disease	Stomach Ulcers
Asthma	Heart Murmur	Mitral Valve Prolapse	Stroke
Cancer	Hepatitis	Other Heart Condition	Substance Abuse
Chest Surgery	High Blood Pressure	Pace Maker	Thyroid Disease
Diabetes		Pregnant/ Nursing	Tuberculosis

Other conditions not listed above? _____
Medications Presently taking _____
Allergic to ANY drugs? (Please list) _____
Do you require Premedication with antibiotics prior to dental treatment? _____
Any conditions relevant to your visit today? _____

_____ _____
Patient Signature *(I certify the above medical information is correct)* *Date*